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..	not available for a specific reference period
...	not applicable
0	true zero or a value rounded to zero
0^s	value rounded to 0 (zero) where there is a meaningful distinction between true zero and the value that was rounded
^{p}	preliminary
^{r}	revised
x	suppressed to meet the confidentiality requirements of the *Statistics Act*
^{E}	use with caution
F	too unreliable to be published
*	significantly different from reference category ($p < 0.05$)

Perceived need for mental health care in Canada: Results from the 2012 Canadian Community Health Survey–Mental Health

by Adam Sunderland and Leanne C. Findlay

Abstract

Background

Past research and national survey data on Canadians' perceived need for mental health care (MHC) have focused on unmet needs overall, and have not considered specific types of MHC needs or the extent to which needs are met.

Data and methods

Using data from the 2012 Canadian Community Health Survey–Mental Health, this article describes the prevalence of perceived MHC needs for information, medication, counselling and other services. The degree to which each type of need was met is explored. Associations between risk factors for having MHC needs and the extent to which needs were met are investigated.

Results

In 2012, an estimated 17% of the population aged 15 or older reported having an MHC need in the past 12 months. Two-thirds (67%) reported that their need was met; for another 21%, the need was partially met; and for 12%, the need was unmet. The most commonly reported need was for counselling, which was also the least likely to be met. Distress was identified as a predictor of perceived MHC need status.

Interpretation

Many Canadians are estimated to have MHC needs, particularly for counselling. People with elevated levels of distress are significantly more likely to have unmet and partially met MHC needs than to have fully met MHC needs, regardless of the presence of mental or substance disorders.

Keywords

Mental illness, mental disorder, distress

Authors

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Many Canadians experience a need for mental health care (MHC), but not all of those needs are met.[1,2] In fact, the presence of mental illness has repeatedly been associated with an MHC need,[1,3] despite evidence-based practices suggesting that mental illness can be successfully treated.[4-7] Rates of unmet needs were higher among people with the criteria for mental illness,[8] especially those with depression.[9] This is relevant considering that, in 2012, an estimated 10% of Canadians experienced a mental disorder (depression, bipolar disorder, generalized anxiety disorder, or alcohol, cannabis or substance abuse or dependence) in the past year.[10]

Beyond mental disorders, other risk factors may affect individuals' needs for MHC and/or the likelihood of those needs being met. Higher levels of distress, independent of a diagnosed mental illness, have been related to MHC needs and service use.[1,3,11] As well, people with chronic physical conditions are more likely to report MHC needs,[12] in particular unmet needs,[2] compared with people who do not have such conditions.

Many studies of needs for MHC have been limited by a focus on perceived unmet needs,[8,13,14] not the degree to which needs are met or unmet.[1,2,8,9] For example, the concept of "partially met" need applies to individuals who have received some MHC but still perceive a need for more. Another limitation of earlier analyses is that researchers have usually examined unmet MHC needs overall, rather than specific types.[2,8,9,15]

Based on data from the 2012 Canadian Community Health Survey–Mental Health (CCHS-MH), this article describes the prevalence of four types of perceived MHC needs (information, medication, counselling, and other) and the degree to which they are met in relation to risk factors for MHC needs, specifically, mental disorders, distress, or chronic physical health condition(s). Possible barriers to receiving MHC are also explored.

Methods

Data source

The cross-sectional 2012 CCHS–MH provides national estimates of major mental disorders and the provision of MHC services. The survey sample consisted of the household population aged 15 or older in the 10 provinces. Excluded from the sample were persons living on reserves and other Aboriginal settlements, full-time members of the Canadian Forces, and the institutionalized population. The response rate was 68.9%, yielding a sample of 25,113 that represented 28.3 million Canadians.[16]

Perceived need and need status

In the literature, needs for MHC are typically measured in terms of perceived need for assistance or treatment, rather than by the presence of a mental disorder or by the use of services.[8,12,13,17] This is because not all persons with diagnosed mental illnesses will perceive a need for treatment,[1,18] and not all persons who perceive that they have a need for MHC will seek care.[2,14] Furthermore, MHC can be helpful to persons with subthreshold levels of mental illness,[19-21] and may prevent the onset of severe mental illness.[22]

The CCHS–MH contained questions about four types of help for problems with emotions, mental health or the use of alcohol or drugs: 1) information about problems, treatments or services; 2) medication; 3) counselling, therapy, or help for problems with personal relationships; and 4) other mental health services. Respondents were asked which types of help they had received in the previous 12 months. For each type received, they were asked if they felt they had received enough. For each type of help not received, they were asked if they felt it was needed. Based on this information, a four-level need status variable was created for each type of MHC: 1) no need; 2) unmet (did not receive that type of help but perceived a need for it); 3) partially met (received help but perceived a need for more); and 4) met (received help and did not perceive a need for more). Dichotomous perceived need variables were also created for each type of need, representing unmet, partially met, or met need (rather than no need). Finally, need status and a dichotomous perceived need variable for "any" need were created by combining across all four need types. Here, "partially met" need represented a need for more of any type of help, or a met need for one type of help, but an unmet need for another type.

Correlates of perceived need for MHC

Analyses of MHC needs often employ Andersen's Behavioural Model of Health Services Use,[8,23,24] which identifies certain *predisposing* characteristics (related to the tendency to use health care services), *enabling* resources (availability of facilities and personnel, and the knowledge and ability to access them) and *needs-related* factors (health status) as being associated with health care use.

Predisposing characteristics

Respondents provided information on sex, age, immigration status, and marital status. Four age groups were defined: 15 to 24; 25 to 44; 45 to 64; and 65 or older. Respondents born outside Canada without Canadian citizenship were identified as immigrants. Marital status was grouped into three categories: married or common-law; divorced, separated or widowed; and single, never married.

Enabling resources

Education, household income, employment status, and geographic location were considered to be enabling resources. Highest level of education was grouped into three categories: less than secondary graduation; secondary graduation; and at least some postsecondary education. Income was represented as the ratio of household income to the low income cut-off,[25] and was divided into quintiles. Employment status indicated whether respondents were employed during the two weeks before the 2012 CCHS–MH interview. Residents of communities of 1,000 or more with a population density of at least 400 persons per square kilometer were classified as living in a population centre (as opposed to a rural area).

Needs-related factors

Mental or substance disorder. The World Mental Health—Composite International Diagnostic Interview 3.0 (WMH-CIDI)[26] is a standardized instrument for the assessment of mental disorders and conditions according to DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) criteria, and is widely used in population surveys.[27,28] Six mental disorders (lifetime and past year) were included in the 2012 CCHS–MH: depression; bipolar disorder; generalized anxiety disorder; alcohol abuse and dependence; cannabis abuse and dependence; and substance abuse and dependence. Diagnostic algorithms identified respondents meeting the criteria for each disorder. The present analysis considered only mental or substance disorders experienced in the past 12 months. Respondents were grouped into four mutually exclusive categories: 1) no mental or substance disorder; 2) one or more mood and/or anxiety disorders (depression, bipolar disorder, or generalized anxiety disorder); 3) one or more substance disorders (alcohol and/or cannabis and/or substance abuse or dependence); and 4) concurrent disorders (mood or anxiety disorder and any substance disorder). Concurrent disorders were those experienced in the same 12-month period, but not necessarily at exactly the same time.

Psychological distress. The K6 scale is a validated measure of psychological distress; values of 13 or more predict severe mental illness.[29] Psychological

distress, however, has been associated with perceived MHC need, independent of a mental health disorder.[1,11] For the current study, the K6 was used as an indicator of distress, not an indicator of mental disorder. A dichotomous variable was created by establishing 4 as a cut-point; K6 levels greater than 4 represent higher distress.[30]

Number of chronic physical conditions. Physical conditions that had been diagnosed by a health professional and that had lasted or were expected to last six months or more (for example, arthritis, hypertension, diabetes) were summed; respondents were categorized as having 0, 1, 2, or 3 or more chronic conditions. Conditions considered to be mental illnesses were excluded from this measure.

Perceived barriers

For each type of unmet or partially met MHC need, respondents reported their perceived barriers to MHC. In a 2002 study,[31] Sanmartin et al. suggested two types of barriers to health care in general: features of the health care system and personal circumstances. Results of other studies[8,15,32] indicate that many people prefer to manage mental health care on their own. Therefore, this analysis grouped the barrier items into three categories: 1) features of the health care system ("help not readily available," "language problems"); 2) personal circumstances ("didn't know how or where to get this kind of help," "haven't gotten around to it yet," "job interfered," "didn't have confidence in the health care system or social services," "couldn't afford to pay," "insurance did not cover," "afraid of what others would think," "other"); and 3) preferred to manage on own.

Analysis

Descriptive statistics were calculated to determine the percentage of Canadians aged 15 or older who perceived MHC needs (any and by type). Needs were explored based on the presence of risk factors for MHC: a mental or substance disorder, distress, and chronic physical conditions. Logistic regression analysis was used to examine independent associations between these risk factors and having any MHC need (versus no need). Predisposing (sex, age group, immigration status, and marital status) and enabling (education, household income, employment status, and population centre/rural) factors were included as covariates.

Among individuals who perceived an MHC need (n = 4,816), need status was identified as the percentage of unmet, partially met, and met needs. Associations between risk factors and need status were explored in multinomial logit regression analyses (any, information, medication, counselling). This technique allows for a comparison between levels of a non-ordered, multi-response dependent variable, whereby the effect of an independent variable can be observed for each level of the dependent variable. In this case, unmet and partially met needs were compared with the met needs reference category. Predisposing and enabling factors were included as covariates.

To explore why MHC needs were not fully met, descriptive analyses examined barriers to MHC among those who reported unmet or partially met needs.

All analyses were conducted using SAS 9.2. Survey sampling weights were applied so that the analyses would be representative of the Canadian population. Bootstrap weights were applied using SUDAAN 11.0 to account for the underestimation of standard errors due to the complex survey design.[33]

Results

One in six has MHC need

In 2012, 17% of Canadians aged 15 or older reported having had a need for MHC in the previous 12 months (Table 1). Because individuals could report more than one type of need, the sum of the percentages reporting specific types of need exceeds 17%: 12% reported a need for counselling; 10% reported a need for medication; 7% reported a need for information; and 1% reported another type of need.

As expected, the prevalence of MHC needs was much higher among people with mental health conditions. Three-quarters of those with a mood or anxiety disorder reported an MHC need. And while just one-quarter with any substance disorder reported an MHC need, approximately nine out of ten with a concurrent substance disorder and a mental disorder perceived an MHC need. Regardless of the mental or substance disorder, the most commonly reported need was for counselling.

Individuals with higher levels of distress and chronic physical conditions more frequently reported having an MHC need than did people with low distress and no chronic physical conditions.

Even when predisposing (for example, age and sex) and enabling (for example, education and household income) characteristics were taken into account, the associations between MHC needs and mental disorders, distress and chronic physical conditions persisted (Table 2). Individuals in each mental or substance disorder category had significantly higher odds of perceiving an MHC need, compared with people without a mental or substance disorder. As well, people with higher distress or chronic physical conditions had elevated odds of perceiving an MHC need, compared with people with low distress or no physical conditions.

Meeting perceived MHC needs

In 2012, an estimated 600,000 Canadians reported that in the previous 12 months they had an unmet MHC need, and more than 1,000,000 had a partially met MHC need (data not shown). For people with an MHC need, the degree to which these needs were met varied with the type of need (Table 3). Needs for medication were the need most likely to be met (91%). As well, about 7 out of 10 who reported a need for information felt that it was met. Counselling needs were the least likely to be met—65% had their need met; for 16%, it was partially met; and for 20%, unmet.

Risk factors for MHC were also related to the need status of perceived MHC needs (Table 4). People with any MHC need

who had a mood or anxiety disorder or concurrent disorders were more likely to have their need partially met (rather than met), compared with individuals who did not have a mental or substance disorder. However, those with a mental or substance disorder were no more likely to have an unmet versus a met need.

Individuals with higher distress were more likely than those with low distress to have both unmet and partially met (rather than met) needs (Table 4). Follow-up analysis (data not shown) explored the association between any MHC need and more detailed distress levels: low (K6 score 0 to 4; 77% of sample); moderate (K6 score 5 to 12; 21%); and high (K6 score 13 or greater; 2%). Because of the high correlation between distress and the presence of a mental disorder (Spearmen rank $r = .4$), mental disorder variables were excluded from this analysis. Compared with people who had low distress, those whose distress level was moderate were more than twice as likely to have unmet or partially met (versus met) MHC needs; those with higher levels of distress were more than three times as likely to have unmet needs and seven times more likely to have partially met needs versus met needs

By contrast, people with two or more chronic physical conditions were less likely to have an unmet (rather than met) MHC need, compared with people who did not have a chronic physical condition (Table 4)

Counselling

Given that counselling was the MHC need most likely to be reported and the least likely to be met, associations between the risk factors and unmet, partially met, and met counselling needs were examined (data not shown). When the predisposing, enabling, and other needs-related factors were taken into account, individuals with a mental disorder were no more likely to have an unmet or partially met (rather than met) counselling need than were individuals without a mental disorder. However, people with higher distress had more than twice the odds of having an unmet or a partially met counselling need (rather than a met need), compared with those with low distress. People with two or more chronic physical conditions were less likely to have unmet counselling needs (rather than met) than were individuals without a chronic physical condition.

Table 1
Prevalence of perceived need for mental health care (MHC), by risk factors for MHC and by type of MHC need, household population aged 15 or older, Canada excluding territories, 2012

	Type of MHC need				
Risk factors for MHC	**Any†**	**Information**	**Medication**	**Counselling**	**Other**
			%		
Total	**17.5**	**6.8**	**9.8**	**12.4**	**0.9**
Mental or substance disorder					
Mood or anxiety disorder	75.3	40.9	50.7	65.7	3.2E
Any substance disorder	25.0	11.2	10.0	20.5	X
Mood or anxiety disorder and any substance disorder	86.1	50.1	56.4	76.4	F
None	12.7	4.0	6.7	8.1	0.7
Distress					
Low (K6 ≤ 4)	10.0	3.0	5.2	6.2	0.6
Higher (K6 > 4)	42.3	19.5	25.1	32.7	1.9
Chronic physical conditions					
None	12.1	4.5	4.8	9.0	0.8
One	17.0	6.5	9.2	11.8	0.9E
Two	21.4	7.4	13.3	15.2	0.9E
Three or more	29.2	13.2	21.4	20.1	1.5E

† because respondents could report more than one type of MHC need, percentages do not sum to "any" need
E use with caution
F too unreliable to be published
X supressed to meet confidentiality requirements of Statistics Act
Source: 2012 Canadian Community Health Survey—Mental Health.

Table 2
Adjusted odds ratios relating risk factors for mental health care (MHC) to perception any MHC need, household population aged 15 or older, Canada excluding territories, 2012

		95% confidence interval	
Risk factors for MHC	**Adjusted odds ratio**	**from**	**to**
Mental or substance disorder			
None†	1.00	...	...
Mood or anxiety disorder	9.17*	7.36	11.43
Any substance disorder	1.92*	1.49	2.48
Mood or anxiety disorder and any substance disorder	19.79*	10.16	38.57
Distress			
Low (K6 ≤ 4)†	1.00	...	...
Higher (K6 > 4)	3.79*	3.29	4.35
Chronic physical conditions			
None†	1.00	...	...
One	1.40*	1.19	1.63
Two	1.69*	1.41	2.03
Three or more	2.44*	2.03	2.92

† reference category
* significantly different from reference category ($p < 0.05$)
... not applicable
Note: Model controls for sex, age group, immigrant status, marital status, education, household income quintile, work status, and living in population centre.
Source: 2012 Canadian Community Health Survey—Mental Health.

Perceived barriers to MHC

The most frequently mentioned barriers to having MHC needs met were related to personal circumstances—cited by almost three-quarters who reported any unmet or partially met need (Table 5). About four out of ten with an unmet or partially met MHC need reported that they preferred to manage the need on their own. One in five mentioned that features of the health care system presented barriers to meeting MHC needs. The distribution of barriers reported were similar across types of need.

Discussion

According to the results from the 2012 CCHS–MH, more than one in six Canadians aged 15 or older experienced a need for mental health care in the previous 12 months. An estimated 600,000 had a perceived unmet MHC need, and more than 1,000,000 had a partially met need. The most common need was for counselling.

Similar to earlier studies that found greater MHC needs among people with concurrent mental or substance disorders,[3,12] the present analysis shows that a large majority of those with a mood or anxiety disorder alone or with a concurrent substance disorder perceived an MHC need, compared with about one-quarter of those with only a substance disorder.

But as was reported in a 2002 study,[12] experiencing a mental disorder was not necessarily associated with the degree to which needs were met. Among individuals who perceived an MHC need, those with a mood or anxiety disorder, with or without a concurrent substance disorder, were more likely to have a partially met (rather than met) MHC need. They were not, however, more likely to have an unmet need, indicating that, along with perceiving a need, they were more likely to use MHC services. This finding illustrates the importance of disentangling the degree to which MHC needs are met.

Regardless of the presence of mental disorders, higher levels of distress were associated with the degree to which perceived MHC needs were met, even when

Table 3
Percentage distribution of mental health care (MHC) need status, by type of MHC need, household population aged 15 or older with perceived MHC need, Canada excluding territories, 2012

Type of MHC need	MHC need status			
	Unmet	Partially met	Met	Total
	%			
Any	12.2	21.1	66.7	100.0
Information	24.5	6.3	69.2	100.0
Medication	4.2	4.9	90.9	100.0
Counselling	19.8	15.7	64.5	100.0
Other	0.0	17.3E	82.7	100.0

E use with caution

Source: 2012 Canadian Community Health Survey—Mental Health

Table 4
Multinominal logit analyses predicting overall mental health care (MHC) need status, by risk factors for MHC, household population aged 15 or older with a perceived MHC need, Canada excluding territories, 2012

Risk factors for MHC need status	Adjusted odds ratio	95% confidence interval	
		from	to
Mood or anxiety disorder			
Unmet need	0.90	0.59	1.38
Partially met need	1.51*	1.15	1.98
Met need †	1.00	...	...
Any substance disorder			
Unmet need	1.27	0.71	2.26
Partially met need	1.42	0.87	2.30
Met need †	1.00	...	...
Mood or anxiety disorder and any substance disorder			
Unmet need	0.91	0.48	1.74
Partially met need	2.03*	1.26	3.27
Met need †	1.00	...	...
Higher distress			
Unmet need	2.61*	1.87	3.63
Partially met need	2.70*	2.03	3.58
Met need †	1.00	...	...
One chronic physical condition			
Unmet need	0.73	0.50	1.06
Partially met need	0.91	0.65	1.28
Met need †	1.00	...	...
Two chronic physical conditions			
Unmet need	0.41*	0.25	0.65
Partially met need	0.88	0.61	1.26
Met need †	1.00	...	...
Three or more chronic physical conditions			
Unmet need	0.41*	0.24	0.71
Partially met need	1.15	0.81	1.64
Met need †	1.00	...	...

† reference category
* significantly different from reference category ($p < 0.05$)
... not applicable

Note: Model controls for sex, age group, immigrant status, marital status, education, household income quintile, work status, and living in population centre.

Source: 2012 Canadian Community Health Survey—Mental Health

What is already known on this subject?

- Many Canadians experience a need for mental health care (MHC), but not all of those needs are met.
- Past research and national survey data on Canadians' perceived need for MHC have focused on unmet need overall, and have not considered specific types of MHC needs or the extent to which needs are met.

What does this study add?

- Based on data from the 2012 Canadian Community Health Survey–Mental Health, an estimated 17% of the population aged 15 or older reported having had an MHC need in the past 12 months.
- Two-thirds (67%) of them reported that the needs were met; for another 21%, the needs were partially met; and for 12%, the needs were unmet.
- The most commonly reported need was for counselling, which was also the least likely to be met.
- Distress was associated with perceived MHC need status.

Table 5
Barriers to receipt of mental health care (MHC), by type of MHC need, household population aged 15 or older with unmet or partially met MHC needs, Canada excluding territories, 2012

Barrier	Type of unmet/partially met MHC need			
	Any	Information	Medication	Counselling
	%			
Features of health care system	19.2	22.4	10.8[E]	17.9
Personal circumstances	73.1	73.7	70.3	71.0
Preferred to manage on own	43.2	36.3	32.3	39.6

[E] use with caution

Note: Because respondents could report more than one type of barrier, sum of percentages exceeds 100%.

Source: 2012 Canadian Community Health Survey—Mental Health.

predisposing and enabling factors were accounted for. However, because the data are cross-sectional, directionality cannot be determined—people with distress may be more likely to perceive unmet needs, or people with unmet needs may be more likely to experience distress.

As in previous research,[12] results suggest that individuals with chronic physical conditions were more likely to have a perceived MHC need, compared with people who did not have such conditions. The current study also found that their MHC needs were less likely to be unmet (rather than met). This may reflect a tendency for people with multiple chronic conditions to have more frequent contact with medical professionals,[34] and thereby be referred for MHC.

Although this analysis suggests a link between physical and mental health, previous research helps highlight the differences between barriers to MHC and to health care in general. In the current study, 19% of perceived unmet or partially met needs were attributed to features of the health care system measured in the 2012 CCHS-MH, and 73% to personal circumstances. By comparison, Sanmartin et al.[31] found 52% of individuals reported that barriers to health care in general were a result of features of the health care system and 69% attributed barriers to personal circumstances. Additionally, in the current study, nearly half of respondents with an unmet or partially met MHC need reported that they preferred to manage the need on their own.

Limitations and future directions

Several limitations of this analysis must be acknowledged. Mental disorders were identified by an algorithm based on responses to the CIDI, not a clinical diagnosis. Also, only certain mental disorders were included on the 2012 CCHS–MH (for instance, personality disorders were not considered). Additionally, the sample did not include the institutionalized population. Taken together, the prevalence of mental disorders and MHC needs may be underestimated.

Moreover, the focus was on *perceptions* of MHC needs, which excludes people who do not perceive a need, but who might benefit from MHC services. Future research based on the CCHS–MH might consider differences in perceived need status by service use.

Finally, this study does not account for some factors that may influence MHC needs—for example, whether individuals have a regular physician or insurance coverage.[24]

Conclusion

The strengths of this analysis include an examination of MHC needs by type (information, medication, counselling, and other), a determination of the degree to which MHC needs are met (fully, partially, or unmet), and a large, population-based sample. The results suggest that many Canadians perceive an MHC need, particularly for counselling. The presence of a mental disorder, higher distress, and chronic physical conditions were positively associated with perceiving an MHC need, many of which were unmet or only partially met. As well, higher levels of distress predicted a greater likelihood that needs would be unmet or partially met. Most perceived barriers to receiving MHC were related to personal circumstances, although almost one in five who reported barriers said they were related to features of the health care system. ■

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